DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

OFFICIAL FILE COPY

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 17

2. STATE: Texas

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
September 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 440.40

7. FEDERAL BUDGET IMPACT: See Attachment
a. FFY 2002 $ -0-
b. FFY 2003 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
See Attachment

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
See Attachment

10. SUBJECT OF AMENDMENT: Amendment No. 612 modifies the nursing facility (NF) reimbursement related to the enhanced direct care staff rate.

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Sent to Governor's Office this date. Comments, if any, will be forwarded upon receipt.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Linda K. Wertz

13. TYPED NAME:
Linda K. Wertz

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:
September 20, 2001

16. RETURN TO:
Linda K. Wertz
State Medicaid Director
Health and Human Services Commission
Post Office Box 13247
Austin, Texas 78711

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
21 SEPTEMBER, 2001

18. DATE APPROVED:
01 November 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
09 September 2001

20. SIGNATURE OF REGIONAL OFFICIAL:
Calvin G. Cline

21. TYPED NAME:
Calvin G. Cline

22. TITLE:
Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Calvin G. Cline
Associate Regional Administrator, Medicaid and State Operations

1301 Young Street, Room 827
Dallas, Texas 75202
Phone (214) 767-6301
Fax (214) 767-0270

November 1, 2001

Our reference: SPA-TX-01-17

Ms. Linda K. Wertz, State Medicaid Director
Texas Health and Human Services Commission
Post Office Box 13247
Austin, TX 78711

Dear Ms. Wertz:

We have reviewed the proposed amendment to your Medicaid State plan submitted under transmittal no. (TN) 01-17, including the revisions submitted on October 10, 2001. Effective September 1, 2001, this amendment revises the nursing facility reimbursement methodology for the direct care staffing enhancement. This amendment allows nursing facilities located in high wage areas that fail to meet the staffing requirements to continue to be eligible for the enhancement if the nursing facilities can demonstrate the enhancement was spent on direct care staff. In addition, nursing facilities that fail to meet the staffing requirements for the enhancement may have a portion of the resulting overpayment reduced if they qualify for the performance-based enhancement.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13)(A) and 1902(a)(30) of the Social Security Act and the implementing federal regulations at 42 CFR 447 Subpart C. We have approved the amendment for incorporation into the official Texas State plan effective on September 1, 2001. We have enclosed a copy of HCFA-179, transmittal no. 01-17, dated November 1, 2001, and the amended plan pages.

If you have any questions, please call Billy Bob Farrell at (214) 767-6449.

Sincerely,

Calvin G. Cline

Calvin G. Cline
Associate Regional Administrator
Division of Medicaid and State Operations

Enclosures

cc: Elliot Weisman, CMSO, PCPG
Commerce Clearing House

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Attachment 4.19-D

REIMBURSEMENT METHODOLOGY FOR NURSING FACILITIES

The Texas Health and Human Services Commission (HHSC), the Single State Medicaid Agency has final approval authority of Medicaid rates. HHSC determines nursing facility (NF) Medicaid payment rates after consideration of analysis of financial and statistical information, and the affect of the reimbursement on achievement of program objectives, including economic conditions and budgetary considerations.

(I) General

(A) Uniform Rates. Reimbursement rates are uniform statewide for the same class of service.

(B) Prospective Rates with a Retrospective Adjustment. Reimbursement rates are determined prospectively with a retrospective adjustment for failure to meet staffing and/or spending requirements.

(C) Unit of Service. The unit of service reimbursed is a day of care provided to a Medicaid client by a Medicaid contracted NF. A day is defined as a 24-hour period extending from midnight to midnight.

(D) Frequency of Rate Determination. Rates are determined for a period of two years based upon odd-year cost reports.

(D) References in the text to the Texas Department of Human Services (DHS) should be considered to be references to HHSC or its designee.

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(F)

* (H) Liability Insurance Costs. Effective September 1, 2001, the portion of the rate accruing from reported general liability insurance costs will only be disbursed to providers certifying that they have purchased general liability insurance acceptable to HHSC and the portion of the rate accruing from reported professional liability insurance costs will only be disbursed to providers certifying that they have purchased professional liability insurance acceptable to HHSC. Providers who cancel or fail to renew their liability coverage during a rate year must notify HHSC within two weeks of the effective date of their cancellation or failure to renew.

* Pen & ink change made per State's 10-10-01 request.

SUPERSEDES: NONE - NEW PAGE

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(VI) Enhanced Direct Care Staff Rate.

(A) Direct care staff cost center. This cost center will include compensation for employee and contract labor Registered Nurses (RNs), Licensed Vocational Nurses (LVNs), medication aides, and nurse aides performing nursing-related duties for Medicaid-contracted beds. For facilities receiving supplemental reimbursement for ventilator-dependent residents or children with tracheostomies, this cost center also includes compensation for employee and contract labor registered Respiratory Therapists and certified Respiratory Therapy Technicians. Staff members performing more than one function in a facility without a differential in pay between functions are categorized at the highest level of licensure or certification they possess.

(B) Rate year. The standard rate year begins on the first day of September and ends on the last day of August of the following year.

(C) Enrollment. An initial enrollment contract amendment is required from each facility choosing to participate in the enhanced direct care staff rate. Participating and nonparticipating facilities may request to modify their enrollment status during any open enrollment period. Enrollment will begin on the first day of July and end on the last day of that same July preceding the rate year for which payments are being determined, unless HHSC notifies facilities prior to the first day of July that the open enrollment has been postponed or canceled. Should conditions warrant, additional enrollment periods may be conducted during a rate year. Facilities which do not submit an enrollment contract amendment by the last day of the open enrollment period will continue at the level of participation of the previous year within available funds.

(D) Determination of staffing requirements for participants. Facilities choosing to participate in the Enhanced Direct Care Staff Rate agree to maintain certain direct care staffing levels. In order to permit facilities the flexibility to substitute RN, LVN and aide (medication aide and nurse aide) staff resources and, at the same time, comply with an overall nursing staff requirement, total nursing staff requirements are expressed in terms of LVN-equivalent minutes. The most recent available, reliable relative compensation levels for RNs, LVNs and aides in Texas NFs, including salaries, wages, payroll taxes and benefits, are used to convert RN and aide minutes into LVN-equivalent minutes. For example, if the most recent available, reliable relative compensation levels for RNs, LVNs, and aides were $0.42, $0.28, and $0.14 per minute respectively, one minute of LVN time would be equivalent to 0.67 minutes of RN time ($0.28 / $0.42 = 0.67), and to two minutes of aide time ($0.28 / $0.14 = 2.00). Conversely, one minute of RN time would be equivalent to 1.5 minutes of LVN time ($0.42 / $0.28 = 1.5), and one minute of aide time would be equivalent to 0.5 minutes of LVN time ($0.14 / $0.28 = 0.5).

(1) Minimum staffing levels. For each participating facility, determine a minimum LVN-equivalent staffing level as follows.

(a) Determine minimum required LVN-equivalent minutes per resident day of service for various types of residents using time study data, cost report information, and other appropriate data sources.

(i) Determine LVN-equivalent minutes associated with Medicare residents based on the data sources from (VI)(D)(1)(a) adjusted for estimated acuity differences between Medicare and Medicaid residents.

(ii) Determine minimum required LVN-equivalent minutes per resident day of service associated with each Texas Index for Level of Effort (TILE) case mix group and additional minimum required minutes for residents reimbursed under the TILE system who also qualify for supplemental reimbursement for ventilator care or pediatric tracheostomy care. These minimum required minutes are determined using the data sources from (VI)(D)(1)(a) adjusted for acuity differences between Medicare and Medicaid residents and other factors.

(b) Based on most recently available, reliable utilization data, determine for each facility the total days of service by TILE group, days of service provided to TILE residents qualifying for Medicaid supplemental reimbursement for ventilator or tracheostomy care, total days of service for Medicare Part A residents in Medicaid contracted beds, and total days of service for all other residents in Medicaid contracted beds.

(c) Multiply the minimum required LVN-equivalent minutes for each TILE group and supplemental TILE reimbursement group from (VI)(D)(1)(a) by the facility's Medicaid days of service in each TILE group and supplemental TILE reimbursement group from (VI)(D)(1)(b) and sum the products.

(d) Multiply the minimum required LVN-equivalent minutes for Medicare residents by the facility's Medicare Part A days of service in Medicaid contracted beds.

(e) Divide the sum from (VI)(D)(1)(c) by the facility's total Medicaid days of service, with a day of service for a Medicaid TILE recipient who also qualifies for a supplemental TILE reimbursement counted as one day of service, compare this result to the minimum required LVN-equivalent minutes for a TILE 207 and multiply the lower of these two figures by the facility's other resident days of service in Medicaid contracted beds.

(f) Sum the results of (VI)(D)(1)(c), (d), and (e), divide the sum by the facility's total days of service in Medicaid contracted beds, with a day of service for a Medicaid TILE recipient who also qualifies for a supplemental TILE reimbursement counted as one day of service. The result of these calculations is the minimum LVN-equivalent minutes per resident day the participating facility must provide.

(2) Enhanced staffing levels. Participating facilities desiring to staff above the minimum requirements from (VI)(D)(1) may request LVN-equivalent staffing enhancements from an array of LVN-equivalent enhanced staffing options and associated add-on payments during enrollment. Enhanced staffing options offered are based upon multiples of one LVN-equivalent minute.

(3) Granting of staffing enhancements. All requested enhancements are divided into two groups: pre-existing enhancements that facilities request to carry over from the prior year and newly-requested enhancements. Newly-requested enhancements may be enhancements requested by facilities that were nonparticipants in the prior year or by facilities that were participants in the prior year desiring to be granted additional enhancements. Using the process described herein, the distribution of pre-existing enhancements is determined. If funds are available after the distribution of pre-existing enhancements, the distribution of newly-requested enhancements is determined.

(a) For each enhancement option, projected Medicaid units of service for facilities requesting that option are determined and multiplied by the rate add-on associated with the option as determined in (VI)(F)(2).

(b) The sum of the products from subparagraph (VI)(D)(3)(a) is compared to available funds.

(c) If the product is less than or equal to available funds, all requested enhancements are granted.

(d) If the product is greater than available funds, enhancements are granted beginning with the lowest level of enhancement and granting each successive level of enhancement until requested enhancements are granted within available funds.

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(G) Staffing requirements for participating facilities. Each participating facility will be required to maintain adjusted LVN-equivalent minutes equal to those determined in (VI)(D). Each participating facility's adjusted LVN-equivalent minutes maintained during the reporting period will be determined as follows.

(1) Determine unadjusted LVN-equivalent minutes maintained. Using facility-specific staffing and spending information, HHSC will determine the unadjusted LVN-equivalent minutes maintained by each facility during the reporting period.

(2) Determine adjusted LVN-equivalent minutes maintained. Compare the unadjusted LVN-equivalent minutes maintained by the facility during the reporting period from (VI)(G)(1) to the LVN-equivalent minutes required of the facility as determined in (VI)(D). The adjusted LVN-equivalent minutes are determined as follows:

(a) If the number of unadjusted LVN-equivalent minutes maintained by the facility during the reporting period is greater than or equal to the number of LVN-equivalent minutes required of the facility or less than the minimum LVN-equivalent minutes required for participation as determined in (VI)(D)(1), the facility's adjusted LVN-equivalent minutes maintained is equal to its unadjusted LVN-equivalent minutes; or

(b) If the number of unadjusted LVN-equivalent minutes maintained by the facility during the reporting period is less than the number of LVN-equivalent minutes required of the facility, but greater than or equal to the minimum LVN-equivalent minutes required for participation as determined in (VI)(D)(1); the following steps are performed.

(i) Determine what the facility's accrued Medicaid fee-for-service and managed care revenue for the reporting period would have been if their staffing requirement had been set at a level consistent with the highest LVN-equivalent minutes that the facility actually maintained, from (VI)(D).

(ii) Determine the facility's adjusted accrued revenue by multiplying the accrued revenue from (VI)(G)(2)(b)(i) by 0.85. Effective for reporting periods beginning on or after September 1, 2002, determine the facility's adjusted accrued revenue by multiplying the accrued revenue from (VI)(G)(2)(b)(i) by 0.90.

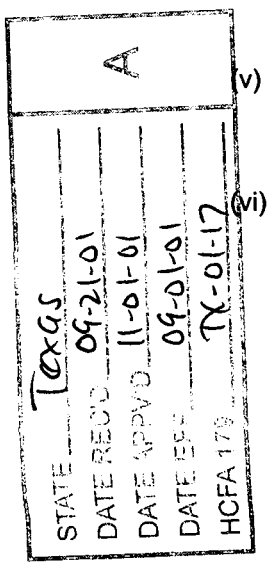
(iii) Determine the facility's accrued allowable Medicaid fee-for-service and managed care direct care staff expenses for the rate year.

(iv) Determine the facility's direct care spending surplus for the reporting period by subtracting the facility's adjusted accrued revenue from (VI)(G)(2)(b)(ii) from the facility's accrued allowable expenses from (VI)(G)(2)(b)(iii).

(v) If the facility's direct care spending surplus from (VI)(G)(2)(b)(iv) is less than or equal to zero, the facility's adjusted LVN-equivalent minutes maintained is equal to the unadjusted LVN-equivalent minutes maintained as calculated in (VI)(G)(1).

(vi) If the facility's direct care spending surplus from (VI)(G)(2)(b)(iv) is greater than zero, the adjusted LVN-equivalent minutes maintained by the facility during the reporting period is set equal to the facility's direct care spending surplus from (VI)(G)(2)(b)(iv) divided by the per diem enhancement add-on for one LVN-equivalent minute as determined in (F)(2) plus the unadjusted LVN-equivalent minutes maintained by the facility during the reporting period from (VI)(G)(1) according to the following formula:

(Direct Care Spending Surplus / Per Diem Enhancement Add-on for One LVN-equivalent Minute) + Unadjusted LVN-equivalent Minutes.



SUPERSEDES: NONE - NEW PAGE

(H) Staffing accountability. Participating facilities will be responsible for maintaining the staffing levels determined in (VI)(D). HHSC will determine the adjusted LVN-equivalent minutes maintained by each facility during the reporting period by the method described in (VI)(G). Participating facilities that fail to maintain staffing at their required level will have their direct care staff rates and staffing requirements adjusted to a level consistent with the highest staffing level that they actually attained and all direct care staff revenues associated with unmet staffing goals will be recouped by HHSC or its designee. In addition, participating facilities that fail to meet the minimum direct care staff requirements for participation will be removed from participation. Facilities removed from participation may re-enroll in the enhanced direct care staff rate during the next enrollment period. Re-enrollments for facilities previously removed from participation are treated as newly-requested enhancements as per (VI)(D)(3) above. Participating facilities that fail to maintain their required LVN-equivalent minutes by two or more LVN-equivalent minutes will have these adjustments remain in effect for the longer of either the remainder of the rate year in which the determination is made plus another full rate year or until the first day of the rate year after funds identified for recoupment are repaid. Interest will be collected from participating facilities that fail to maintain their required LVN-equivalent minutes as follows:

(1) Determine the average excess funds available to the provider over the reporting period as the staffing recoupment amount divided by two.

(2) Determine the annualized average three-month United States Treasury Bill rate during the provider's reporting period as the unweighted monthly average for all months included, either partially or fully, in the reporting period.

(3) Determine the interest rate on the recoupment amount by multiplying the annualized average rate from (VI)(H)(2) above by the number of days in the reporting period divided by the number of days in the rate year.

(4) Determine the interest on the recoupment amount by multiplying the recoupment interest rate calculated in (VI)(H)(3) by the average excess funds available to the provider over the reporting period from (VI)(H)(1).

(I) Spending requirements for all facilities. All facilities, participants and nonparticipants alike, are subject to a direct care staff spending requirement with recoupment calculated as follows:

(1) At the end of the rate year, a spending floor will be calculated by multiplying accrued Medicaid fee-for-service and managed care direct care staff revenues by 0.85. Effective September 1, 2002, the spending floor will be calculated by multiplying accrued Medicaid fee-for-service and managed care direct care staff revenues by 0.90.

(2) Accrued allowable Medicaid direct care staff expenses for the rate year will be compared to the spending floor from (VI)(I)(1). HHSC or its designee will recoup the difference between the spending floor and accrued allowable Medicaid direct care staff expenses from facilities whose Medicaid direct care staff spending is less than their spending floor.

(3) In cases where a parent company, sole member or governmental body controls more than one nursing facility contract, the parent company, sole member or governmental body may request to have its contracts' compliance with the spending requirements evaluated in the aggregate for all contracts it controlled at the end of the rate year or at the effective date of the change of ownership or termination of its last nursing facility contract.

(J) Mitigation of recoupment. Recoupment of funds described in (VI)(I) may be mitigated as follows.

(1) Dietary and Fixed Capital Mitigation. Recoupment of funds described in (VI)(I) may be mitigated by high dietary and/or fixed capital expenses as follows.

(a) Calculate dietary cost deficit. At the end of the facility's rate year, accrued Medicaid dietary per diem revenues will be compared to accrued, allowable Medicaid dietary per diem costs. If costs are greater than revenues, the dietary per diem cost deficit will be equal to the difference between accrued, allowable Medicaid dietary per diem costs and accrued Medicaid dietary per diem revenues. If costs are less than revenues, the dietary cost deficit will be equal to zero.

(b) Calculate dietary revenue surplus. At the end of the facility's rate year, accrued Medicaid dietary per diem revenues will be compared to accrued, allowable Medicaid dietary per diem costs. If revenues are greater than costs, the dietary per diem revenue surplus will be equal to the difference between accrued Medicaid dietary per diem revenues and accrued, allowable Medicaid dietary per diem costs. If revenues are less than costs, the dietary revenue surplus will be equal to zero.

(c) Calculate fixed capital cost deficit. At the end of the facility's rate year, accrued Medicaid fixed capital per diem revenues will be compared to accrued, allowable Medicaid fixed capital per diem costs (i.e., building and building equipment depreciation or lease expense, mortgage interest, land improvements depreciation and leasehold improvements amortization). If costs are greater than revenues, the fixed capital cost per diem deficit will be equal to the difference between accrued, allowable Medicaid fixed capital per diem costs and accrued Medicaid fixed capital per diem revenues. If costs are less than revenues, the fixed capital cost deficit will be equal to zero. For purposes of this paragraph, fixed capital per diem costs of facilities with occupancy rates below 85% are adjusted to the cost per diem the facility would have accrued had it maintained an 85% occupancy rate throughout the rate year. For each facility whose occupancy falls below 85%, an adjustment factor is calculated as follows: adjustment factor = 1.00 - (facility's occupancy rate / .85). This adjustment factor is then multiplied by accrued, allowable Medicaid fixed capital per diem costs, and the result of this calculation is subtracted from accrued, allowable Medicaid fixed capital per diem costs.

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(d) Calculate fixed capital revenue surplus. At the end of the facility's rate year, accrued Medicaid fixed capital per diem revenues will be compared to accrued, allowable Medicaid fixed capital per diem costs as defined in (VI)(J)(c). If revenues are greater than costs, the fixed capital revenue per diem surplus will be equal to the difference between accrued Medicaid fixed capital per diem revenues and accrued, allowable Medicaid fixed capital per diem costs. If revenues are less than costs, the fixed capital revenue surplus will be equal to zero. For purposes of this paragraph, fixed capital per diem costs of facilities with occupancy rates below 85% are adjusted to the cost per diem the facility would have accrued had it maintained an 85% occupancy rate throughout the rate year. For each facility whose occupancy falls below 85%, an adjustment factor is calculated as follows: adjustment factor = 1.00 - (facility's occupancy rate / .85). This adjustment factor is then multiplied by accrued, allowable Medicaid fixed capital per diem costs, and the result of this calculation is subtracted from accrued, allowable Medicaid fixed capital per diem costs.

(e) Facilities with a dietary per diem cost deficit will have their dietary per diem cost deficit reduced by their fixed capital per diem revenue surplus, if any. Any remaining dietary per diem cost deficit will be capped at $2.00 per diem.

(f) Facilities with a fixed capital cost per diem deficit will have their fixed capital cost per diem deficit reduced by their dietary revenue per diem surplus, if any. Any remaining fixed capital per diem cost deficit will be capped at $2.00 per diem.

(g) Each facility's recoupment, as calculated in (VI)(I), will be reduced by the sum of that facility's dietary per diem cost deficit as calculated in (VI)(J)(e) and its fixed capital per diem cost deficit as calculated in (VI)(J)(f).

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(2) Performance-based Mitigation. Recoupment of funds described in (VI)(J)(1)(g) will be mitigated based upon each facility's compliance with state and federal regulations as well as on the basis of resident outcomes as follows.

(a) Calculation of Performance-based Mitigation Index. Calculate the performance-based mitigation index (PMI) using the formula:

$$PMI = (A+B) \times C$$

Where "A", "B", and "C" are the performance weights as detailed (VII)(L), (M), and (I) for potential advantages, potential disadvantages, and regulatory compliance, respectively. The performance weights used in the calculation of the PMI will be those calculated for the service period as defined in (VII)(E) that coincides with the rate year to which the recoupment described in (VI)(I) applies.

(b) Recoupment eligible for Performance-based Mitigation. Recoupment eligible for Performance-based Mitigation is limited to what the facility's recoupment as described in (VI)(J)(1)(g) would have been if the facility had been a nonparticipant in the enhancement program during the reporting period.

(c) Calculation of Performance-based Mitigation. For each facility, multiply the PMI from (VI)(J)(2)(a) by the recoupment eligible for Performance-based Mitigation from (VI)(J)(2)(b). The resulting product is the performance-based mitigation.

(d) Determination of recoupment after Performance-based Mitigation. Each facility's recoupment as calculated in (VI)(J)(1)(g) will be reduced by that facility's performance-based mitigation from (VI)(J)(2)(c).

(e) In cases where a responsible entity has requested to have its contracts' compliance with the spending requirements be evaluated in the aggregate, performance-based mitigation will be based on the lowest PMI associated with any of its contracts.

(f) Facilities for which a PMI cannot be calculated due to missing, invalid or unverifiable data are not eligible for performance-based mitigation.

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(K) Medicaid Swing Bed Program for Rural Hospitals. When a rural hospital participating in the Medicaid swing bed program furnishes NF nursing care to a Medicaid recipient, DHS makes payment to the hospital using the same procedures, the same case-mix methodology and the same TILE rates that HHSC authorizes for reimbursing NFs participating in the enhanced direct care staff rate at the minimum level required for participation. These hospitals are not subject to the staffing and spending requirements.

(L) Reinvestment. HHSC has the option to reinvest recouped funds in the enhanced direct care staff rate program.

(1) Identify qualifying facilities. Facilities meeting the following criteria during the most recent completed reporting period are qualifying facilities for reinvestment purposes.

(a) The facility was a participant in the enhanced direct care staff rate.

(b) The facility requested a higher level of enhancement than it was awarded.

(c) The facility's unadjusted LVN-equivalent minutes as determined in (VI)(G)(1) were greater than the number of LVN-minutes required of the facility as determined in (VI)(D).

(d) The facility met its spending requirement as determined in (VI)(I).

(2) Distribution of available reinvestment funds. Available funds are distributed as described below.

(a) HHSC determines units of service provided during the most recent completed reporting period by qualifying facilities requesting and achieving, with unadjusted LVN-equivalent minutes as determined in (VI)(G)(1), each enhancement option above the maximum enhancement option awarded during the reporting period and multiplies this number by the rate add-on associated with that enhancement in effect during the reporting period.

(b) HHSC compares the sum of the products from (VI)(L)(2)(a) to funds available for reinvestment.

(i) If the product is less than or equal to available funds, all requested enhancements for qualifying facilities are retroactively awarded for the reporting period.

(ii) If the product is greater than available funds, retroactive enhancements are granted beginning with the lowest level of enhancement and granting each successive level of enhancement until requested enhancements are granted within available funds.

(3) All retroactive enhancements are subject to spending requirements detailed in (VI)(I).

(4) Retroactively awarded enhancements do not qualify as pre-existing enhancements for enrollment purposes.

(5) Notification of reinvested enhancements. Qualifying facilities are notifed in a manner determined by HHSC, as to the award of reinvested enhancements.

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Attachment to HCFA-179 for
Transmittal No. 01-17, Amendment 612

Number of the Plan Section or Attachment	Number of the Superseded Plan Section or Attachment
Attachment 4.19-D	Attachment 4.19-D
Page 1	Page 1 (TN00-14)
Page 4f	New
Page 6	Page 6 (TN01-05)
Page 6a	Page 6a (TN00-07)
Page 6b	Page 6b (TN01-05)
Page 6e1	New
Page 6f	Page 6f (TN01-05)
Page 6g	Page 6g (TN00-07)
Page 6h	Page 6h (TN00-07)
Page 6i	New
Page 6j	New